LETTER TO THE EDITOR

Spontaneous appendicocutaneous fistula: exceptional mode of presentation of a case of advanced acute appendicitis

Fístula apendicocutánea espontánea: excepcional modo de presentación de un caso de apendicitis aguda evolucionada

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Mr. Editor:

We present the case of a 35-year-old man with no previous request for health care, who attended for a 3-year history of chronic low-output suppuration through a fistulous orifice at the abdominal wall, adjacent to the iliac bone, and insidious pain in right iliac fossa.

Contrast-enhanced computed tomography scan (Fig. 1) identified the appendix with an appendicolith, distal segment distension, parietal thickening, and increased contrast uptake associated with inflammatory changes. In addition, there was adjacent fat reticulation and a fistulous tract that communicated the tip of the appendix with the cutaneous surface.

Acute appendicitis can evolve insidiously and exceptionally lead to the development of a fistulous tract secondary to primary and non-iatrogenic perforation of the swollen appendix to a nearby epithelial surface, in our case cutaneous, since it was an enterocutaneous fistula. This is the least common type of enteric fistula, and some authors, by analogy with empyema necessitatis, have called it appendicitis necessitatis[1]. The variable location of the fistula cutaneous opening is related to the variable position of the appendiceal tip[2].

The most common appendicular fistulas are those internal to hollow viscera, in order of frequency, appendicovesical, appendicointestinal (ileum, cecum, duodenum, ascending colon and Meckel's diverticulum) and appendicouterine, while appendicocutaneous fistulas are extremely rare[2,3].

Although in most cases fistulas are preceded by subcutaneous abscesses that after draining to the skin tend to lose the fistulous course with intestinal lumen[1], their persistence, as in this case, is due to the presence of an appendicolith, a carcinoid tumor or tuberculosis that prevent spontaneous closure[2,4].

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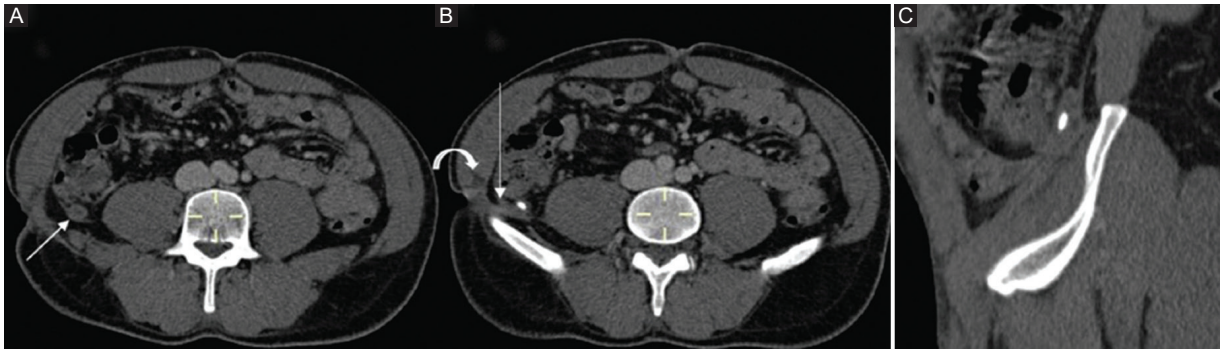

Figure 1. *Computed tomography images with intravenous contrast at venous phase.* **A:** *axial image showing the distended appendix distal segment, with thickened wall with increased uptake.* **B:** *axial image in a section just proximal to the anterior one showing the hyperdense appendicolith and allowing to identify the fistulous path (straight arrow), which extends from the appendix to the cutaneous surface; a small abscessed collection can also be observed on adjacent musculature (curved arrow).* **C:** *sagittal image showing appendix ascending retrocecal location, with appendicolith and distal appendicular segment distension.*

Conflicts of interest

The authors refer not to have conflicts of interest.

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Ethical disclosures

Protection of human and animal subjects. The authors declare that no experiments were performed on humans or animals for this research.

Confidentiality of data. The authors declare that they have followed the protocols of their work center on the publication of patient data.

Right to privacy and informed consent. The authors have obtained informed consent from the patients and/or subjects referred to in the article. This document is in the possession of the corresponding author.

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